Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 18, 2020	2020_725522_0011	020817-20	Complaint

Licensee/Titulaire de permis

CVH (No. 5) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Country Village Homes - Woodslee
440 County Road 8, R.R. #2 Woodslee ON N0R 1V0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 3, 4, 5, 9, and 10, 2020.

The following intake was inspected:
Complaint IL-83685-LO/Log #020817-20 related to improper care.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Dietary Manager, Registered Nurses, a Registered Practical Nurse, Registered Dietitians, a Personal Support Worker, a Physician and a family member.

The inspector also reviewed resident clinical records, hospital records, the home's complaints folder and investigative notes, and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition plan of care for residents #001, #002 and #003 provided clear direction.

Review of resident #003's Nutrition Priority Screen noted resident #003 was a high nutritional risk, and did not meet their required daily nutritional intake.

Nutritional progress notes entered by the registered dietitian indicated resident #003 had inadequate food intake and staff were to provide "**+++** encouragement with oral intake."

A review of resident #003's care plan under the 'Eating' focus did not include that staff were to provide +++ encouragement with meals due to resident #003's inadequate intake.

In an interview, Director of Care (DOC) #101 stated registered staff had informed them that resident #003 required additional time to feed. DOC #101 acknowledged if resident #003 required that much time and encouragement it should be included in resident #003's care plan. [s. 6. (1) (c)]

2. A review of resident #002's nutritional progress notes entered by the registered dietitian indicated staff were to continue to provide assistance, cuing and +++ encouragement with meals. The note also indicated specific interventions when feeding resident #002.

Review of resident #002's care plan under the 'Eating' focus did not include that staff were to provide assistance, cuing and +++ encouragement with meals and specific interventions for feeding resident #002.

In an interview, Director of Care (DOC) #101 acknowledged that there were no interventions related to resident #002 needing assistance, cuing and +++ encouragement with meals and the specific interventions the dietitian had documented in their notes. DOC #101 acknowledged that information should be included in resident #002's care plan. [s. 6. (1) (c)]

3. Review of resident #001's Nutrition Assessment noted staff were to provide resident #001 with "**++** encouragement for oral intake" and that resident #001 ate 26-75% of most meals and refused most snacks.

In an interview, Personal Support Worker (PSW) #105 stated resident #001 was difficult to feed and displayed specific behaviours when they were fed. PSW #105 stated that sometimes they needed to re-approach resident #001 when they behaved this way.

Review of resident #001's care plan under the 'Eating' focus did not include that staff were to provide resident #001 with ++ encouragement for oral intake, that resident #001 was difficult to feed, displayed behaviours when being fed and that staff should re-approach resident #001 when they behaved this way.

In an interview, Director of Care #101 acknowledged that there were no interventions in resident #001's care plan related to resident #001 needing ++ encouragement for oral intake, that resident #001 displayed behaviours when being fed and that staff needed to re-approach resident to encourage intake.

Sources:
Nutrition Assessments, Nutrition Priority Screens, progress notes, and care plans for residents #001, #002 and #003, Extendicare's "Nutrition Care Planning" policy #NC-04-01-07 (last updated March 2019), interviews with Registered Nurse #102, Dietary Manager #107, PSW #105, Registered Dietitians #108 and #109 and DOC #101. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident's nutrition plan of care provides clear direction, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 and #003's plan of care was based on an interdisciplinary assessment of the residents' hydration status and any risks related to hydration.

Review of resident #003's assessments noted there were 23 Hydration Assessments completed over a nine month period due to resident #003's reduced fluid intake.

Review of resident #003's Nutrition - Priority Screen noted resident #003 was a high nutritional risk, and had a poor or changed fluid intake.

Review of resident #003's nutritional progress notes over a nine month period entered by the registered dietitian indicated resident #003 had inadequate fluid intake and staff were to provide "+++ encouragement with oral intake."

Review of resident #003's care plan noted the absence of a hydration focus and interventions related to reduced fluid intake and that staff were to provide +++ encouragement with meals due to inadequate intake.

In an interview, Director of Care (DOC) #101 stated registered staff had informed her that resident #003 required additional time to feed. DOC #101 acknowledged that resident #003 should have a hydration focus on their care plan due to inadequate fluid intake. [s. 26. (3) 14.]

2. Review of resident #001's Nutrition-Registered Dietitian Admission Assessment noted resident #001 had an inadequate fluid intake related to poor intake at meals and snacks.

Review of resident #001's Nutrition Assessment noted staff were to provide resident #001 with "++ encouragement for oral intake".

Review of resident #001's assessments noted 18 Hydration Risk Assessments were completed over a six month period which noted resident #001 was stable but chronically consumed less fluid than recommended and staff were to encourage fluid intake.

Review of resident's care plan noted no focus related to hydration. Under the 'Eating' focus an intervention was recently added to promote fluid intake.

In an interview, Registered Nurse #103 stated if a resident consistently had a decreased intake of fluids it should be care planned by the Registered Dietitian (RD). RN #103 stated they believed it would be under the eating focus as they have not seen a focus for hydration care planned.

In an interview, RD #108 verified there was no hydration focus for resident #001 and they had recently added to increase fluid intake to resident #001's care plan under the eating focus.

Sources:
Nutrition Assessments, Nutrition Priority Screens, Hydration Assessments, progress notes, and care plans for residents #001 and #003, Extendicare's "Nutrition Care Planning" policy #NC-04-01-07 (last updated March 2019), interviews with Registered Nurses #102 and #103, PSW #105, Registered Dietitians #108 and #109 and Director of Care #101. [s. 26. (3) 14.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident's plan of care is based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Review of the home's Complaints folder noted documentation that resident #001's Power of Attorneys (POAs) had met with the Executive Director (ED) and Director of Care (DOC) with concerns related to improper care and neglect of resident #001.

In an interview, ED #100 and DOC #101 verified they had met with resident #001's POA regarding their concerns, investigated the concerns and determined that they were unfounded.

ED #100 acknowledged they had not reported the allegations of improper care and neglect immediately to the Director as they had not taken the POAs concerns as a compliant regarding resident #001's care but rather as questions regarding their care.

Sources
The home's Complaints folder; the LTCH's investigative notes; the
Ministry of Long-Term Care - Long-Term Care Homes Portal and interviews with resident #001's POA, Director of Care #101 and Executive Director #100. [s. 24. (1)]

Issued on this 19th day of November, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.